Aflac

CONTINENTAL AMERICAN INSURANCE COMPANY

P.O. Box 427 Columbia, South Carolina 29202 800.206.8826

Group Short Term Disability Insurance
Certificate of Coverage

Short term disability insurance provides financial protection by paying a benefit in the event of a disability.

POLICYHOLDER: Swift Transportation Co., LLC

POLICY NUMBER: GLD0000142

POLICY EFFECTIVE DATE: January 1, 2026

POLICY SITUS: Arizona

Continental American Insurance Company (referred to as CAIC) welcomes you as a Certificateholder. This is your Certificate of Coverage (Certificate) as long as you are eligible for coverage, and you become insured. Your benefits and rights under the policy will not be less than those stated in this Certificate. **We certify that you are insured for the benefits described in this Certificate, subject to the provisions of this Certificate.**

READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS.

POLICY SITUS: Arizona
The policy is issued in and governed by the laws of the of the Policy Situs stated above, and in compliance with the Interstate Insurance Product Regulation Commission standards, and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Your coverage may be terminated or changed under the terms and provisions of the policy. You may inspect a copy of the policy by contacting the Policyholder. We will only make changes that are consistent with Interstate Insurance Product Regulation Commission ("the Commission") standards and any endorsements or amendments used to effect such changes are subject to prior approval by the Commission and will not affect the insurance provided until the effective date of the change unless retroactivity is required by the Interstate Insurance Product Regulation Commission.

If the terms and provisions of this Certificate (issued to you) are different from the policy (issued to the Policyholder), the policy will govern. Your coverage may be terminated or changed under the terms and provisions of the policy.

For purposes of effective dates and ending dates under this Certificate, all days begin at 12:01 a.m. and end at 12:00 a.m. midnight local time at the Policyholder's place of business.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
The policy and this Certificate have been approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the policy and this Certificate that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for group disability insurance is hereby amended to conform to the Interstate Insurance Product Regulation Commission standards for group disability insurance as of the provision's effective date.

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

The insurance department name and phone number of the Policy Situs appears on the listing following the Table of Contents.

The policy covers disabilities due to Non-Occupational Sickness or Injury.

TABLE OF CONTENTS

STATE INSURANCE DEPARTMENT CONTACT INFORMATION

State	Insurance Department	Main Phone
Alabama	Alabama Department of Insurance	(334) 269-3550
Alaska	Alaska Division of Insurance	(907) 269-7900
Arizona	Arizona Department of Insurance	(602) 364-2499
Arkansas	Arkansas Insurance Department	(501) 371-2600
Colorado	Colorado Division of Insurance	(303) 894-7499
Connecticut	State of Connecticut Insurance Department	(800) 203 2447
Delaware	Delaware Department of Insurance	(800) 282-8611
Georgia	Georgia Department of Insurance	(404) 656-2056
Hawaii	Hawaii Insurance Division	(808) 586-2790
Idaho	Idaho Department of Insurance	(208) 334-4250
Illinois	Illinois Department of Insurance	(217) 782-4515
Indiana	Indiana Department of Insurance	(317) 232-2385
Iowa	Division of Insurance	(515) 281-5705
Kansas	Kansas Department of Insurance	(785) 296-3071
Kentucky	Kentucky Office of Insurance	(502) 564-3630
Louisiana	Department of Insurance	(800) 259-5300
Maine	Maine Bureau of Insurance	(207) 624-8475
Maryland	Maryland Insurance Administration	(410) 468-2090
Massachusetts	Division of Insurance	(617) 521-7794
Michigan	Michigan Department of Insurance and Financial Services	(877) 999-6442
Minnesota	Minnesota Department of Commerce	(651) 539-1500
Mississippi	Mississippi Insurance Department	(800) 562-2957
Missouri	Missouri Department of Insurance, Financial Institutions and Professional Registration	(573) 751-3365
Nebraska	Nebraska Department of Insurance	(402) 471-2201
Nevada	Nevada Division of Insurance	(775) 687-0700
New Hampshire	New Hampshire Department of Insurance	(603) 271-2261
New Jersey	New Jersey Department of Banking and Insurance	(609) 292-7272
New Mexico	Office of Superintendent of Insurance	(505) 827-4601

STATE INSURANCE DEPARTMENT CONTACT INFORMATION

State	Insurance Department	Main Phone
North Carolina	North Carolina Department of Insurance	(855) 408-1212
North Dakota	North Dakota Insurance Department	(701) 328-2440
Ohio	Ohio Department of Insurance	(614) 644-2658
Oklahoma	Oklahoma Department of Insurance	(405) 521-2828
Oregon	Oregon Insurance Division Consumer Advocacy Unit	(503) 947-7984
Pennsylvania	Pennsylvania Department of Insurance	(717) 787-2317
Puerto Rico	Puerto Rico Department of Insurance	(787) 304-8686
Rhode Island	Rhode Island Insurance Division	(401) 462-9520
South Carolina	South Carolina Department of Insurance	(803) 737-6180
Tennessee	Tennessee Department of Commerce & Insurance	(615) 741-2241
Texas	Texas Department of Insurance	(800) 252-3439
Utah	Utah Department of Insurance	(801) 538-3800
Vermont	Vermont Division of Insurance	(802) 828-3301
Virginia	Virginia Bureau of Insurance	(804) 371-9741
Washington	Washington State Office of Insurance	(360) 725-7000
West Virginia	Offices of the Insurance Commission	(304) 558-3354
Wisconsin	Office of the Commissioner of Insurance	(608) 266-3585

SPECIAL NOTICES

Continental American Insurance Company

Toll Free Number:	800.206.8826 TTY/RTT 711
Claim Information Toll Free Number:	800.206.8826 TTY/RTT 711
Dedicated Customer Number:	800.264.2593

PLEASE READ THIS CERTIFICATE CAREFULLY

STATE NOTICES

ARKANSAS

QUESTIONS OR PROBLEMS WITH YOUR POLICY?

If you have any questions or problems with your Policy, you may contact us at the address below or one of the other organizations listed:

Continental American Insurance Company
1932 Wynnton Road
Columbus, GA 31999
Telephone: 800.206.8826

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2640 or (800) 852-5494

ARIZONA

Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully

COLORADO

THIS IS A SUPPLEMENTAL HEALTH PLAN THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS PLAN CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS PLAN CAREFULLY TO AVOID DUPLICATION OF COVERAGE.

GEORGIA

NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

FLORIDA

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

IDAHO

If you need the assistance of the governmental agency that regulates the business of insurance, you can contact the Idaho Department of Insurance by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
P.O. Box 83720-0043

1-800-721-37272 or 208-334-4250 or www.DOI.Idaho.gov

INDIANA

NOTICE TO EMPLOYEES

Questions regarding your Policy or coverage should be directed to:

Continental American Insurance Company
1932 Wynnton Road, Columbus, GA 31999
800.206.8826

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street
Suite 300
Indianapolis, IN 46204

Consumer Hotline:

1-800-622-4461

In the Indianapolis Area:

1-317-232-2395

Complaints can be filed electronically at www.in.gov/idoi

ILLINOIS

NOTICE TO EMPLOYEES - ILLINOIS

This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:

Continental American Insurance Company
1932 Wynnton Road, Columbus, GA 31999
800.206.8826

You may file a consumer complaint online at https://idoi.illinois.gov/ or by mail. The Department maintains a Consumer Division in Chicago and in Springfield at the addresses listed below.

Illinois Department of Insurance
115 S. LaSalle Street, 13th Floor
Chicago, IL 60603
(312) 814-2420

Illinois Department of Insurance
320 W Washington St
Springfield, IL 62767
(217) 782-4515

MARYLAND

For Maryland Residents:
The Group Insurance Contract providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

NORTH CAROLINA

For North Carolina Residents
Notice: This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but it issued under a group master policy located in another state and may be governed by that state's laws.

OKLAHOMA

For Oklahoma Residents
Notice: Certificates issued for delivery in Oklahoma are governed by the certificate and Oklahoma laws not the state where the master policy is issued

OREGON

OREGON RESIDENTS
If you become eligible for benefits under this certificate, you may also be eligible for leave benefits under the Paid Leave Oregon Program. You may be required to apply for such benefits and pursue your application for Oregon Paid Leave program through the highest level of appeal. Benefits paid under this plan may be reduced by the amount received under the Paid Leave Oregon Program.

TEXAS

FOR TEXAS RESIDENTS
THE INSURANCE POLICY UNDER WHICH THE CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIVBER TO THE WORKERS' COMPENSATION SYSTEM

WISCONSIN

NOTICE TO EMPLOYEES – WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Continental American Insurance Company
1932 Wynnton Road, Columbus, GA 31999
800.206.8826

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
Toll-Free: (800) 236-8517

Telephone: (608) 266-0103

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104 Fax
(512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Aflac first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part of or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Pueda escribir al Departmento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104 Fax
(512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Aflac primero. Si no se resuelve la disputa, puede entonces communicarse con el departmento (TDI)

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion de documento adjunto.

SHORT TERM DISABILITY SCHEDULE OF BENEFITS

The short term disability policy provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began, subject to all policy provisions.

POLICYHOLDER: Swift Transportation Co., LLC

ADDRESS: 2200 South 75th Ave

Phoenix, AZ 85043

POLICY NUMBER: GLD0000142

POLICY EFFECTIVE DATE: January 1, 2026

POLICY ANNIVERSARY DATE: January 1, 2027, and each following January 1st.

ELIGIBLE CLASS:
All persons in the following class are eligible for Employee coverage:

Class 2: All full-time Active at Work Driver Trainees, Experienced Driver(s) and Non-Driver Employees working in the United States electing $400 maximum.

Minimum Hours Requirement: 30 hours per week.

Waiting Period: 1st of the month following 30 days.

Credit Prior Service:

We will apply any prior period of work with your Employer toward the Waiting Period to determine your Eligibility Date.

Who Pays for the Coverage:

Contributory Plan: You pay the cost of your coverage.

Elimination Period: 7 calendar days for disability due to Injury.

7 calendar days for disability due to Sickness.

The Elimination Period begins on the first day of your disability.

Benefits for a Payable Claim begin the day after the Elimination Period is completed.

Weekly Benefit:

Contributory Plan: 60% of Weekly Earnings to a Maximum Benefit of $400 per week.

Your benefit may be reduced by any Deductible Sources of Income and adjusted by any Disability Earnings. Some disabilities may not be covered or may have Limited Coverage under the policy.

Maximum Weekly Benefit Amount: $400 per week.

Minimum Weekly Benefit Amount: $25

Weekly Earnings:

"Weekly Earnings" means your gross weekly income from your Employer as of the last date worked. It includes your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer. It does not include any expenses, allowances, and other unusual and non-recurring compensation, such as relocation assistance and event awards.

Earnings, whether for a full year or partial year, will be converted to a weekly amount for the purpose of calculating the Weekly Benefit.

Maximum Period of Payment: 25 weeks. If disability is the result of a Pre-Existing Condition, the Maximum Period of Payment is 4 weeks.

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below.

Unless defined differently within a particular provision, the terms “you” and “your” mean the insured Employee. The terms “we”, “our”, and “us”, mean Continental American Insurance Company. Other defined terms will appear in the Certificate with their initial letters capitalized. The plural use of a term defined in the singular will share the same meaning.

Accident means a sudden, unexpected event that was not reasonably foreseeable.

Active Employment/Active-At-Work mean you are working for your Employer for earnings that are paid regularly and that you are performing the Material and Substantial Duties of your Own Occupation. You must be working at least the minimum number of hours as described under the Minimum Hours Requirement in the *Schedule of Benefits*.

To be in active employment, your work site must be:

- your Employer’s usual place of business;
- an alternative work site at the direction of your Employer, including your current residence, even if temporary; or a location to which your job requires you to travel.

We will consider you to be in active employment on weekends, holidays, vacations, and paid time off program that your Employer has approved and during a temporary business closure not to exceed 1 day if you were in active employment on the last scheduled workday immediately prior to such time off. A temporary business closure includes a closure due to inclement weather, power outage or public health agency orders.

If your employment status is being continued under a severance or termination agreement, you will not be considered in active employment.

Temporary workers are excluded from coverage. Seasonal workers are excluded from coverage.

Appropriate Care means that you:

- visit a Physician as frequently as medically required according to standard medical practice to effectively treat and manage your disabling condition(s); and
- receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Physician whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice; and
- have the obligation to minimize your disabling condition including having corrective treatment or minor surgery.

Certificateholder means an Employee who is eligible for benefits provided by the policy, who has received a Certificate, and for whom premium has been paid. Unless otherwise specified, the certificateholder is entitled to exercise the rights and benefits granted under the Certificates attached to the policy.

Complication of Pregnancy means a condition, when pregnancy is not terminated, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy. Complication of pregnancy includes, but is not limited to, non-elective cesarean section; termination of ectopic pregnancy; spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible; acute nephritis or nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity. It does not include false labor; occasional spotting; morning Sickness; Physician prescribed rest; hyperemesis gravidarum; pre-eclampsia; or any other condition associated with the management of a difficult pregnancy, not consisting of a nosologically distinct complication of pregnancy.

Confined or Confinement means a Hospital, Health Facility, or Institution stay of at least 8 hours per day.

Contribution means the amount the Policyholder may require you to pay towards the total premium that we charge for the insurance provided under the policy.

Contributory Plan/ Contributory Insurance means insurance for which the Policyholder requires you to pay all or a portion of the premium. This certificate specifies who pays the cost of the coverage.

Deductible Sources of Income means income from other sources as listed in this Certificate which you receive or are eligible to receive while you are disabled. This income will be subtracted from your Gross Weekly Benefit.

Disability Earnings means the income which you receive from working while you are disabled. Disability earnings do not include earnings from secondary employment if such employment began prior to your date of disability; however, it does include any increase in earnings from the secondary employment occurring after your date of disability.

Eligibility Date means the date you become eligible for insurance.

Elimination Period means a period of continuous disability that must be satisfied before you are eligible to receive benefits from this plan.

Employee means a person defined as such by the Policyholder. Employee excludes in any case, part-time employees, temporary employees and employees who work for the Employer less than the number of hours per week indicated in the *Schedule of Benefits*.

Employer means the Policyholder and any entity that has been approved by us for coverage under the policy issued to the Policyholder. Employer includes any division, subsidiary, or affiliated company named in the policy.

Evidence of Insurability is information about your medical history and any other information about your insurability that we may reasonably require. We will use this information to determine if your request for coverage or increases in coverage will become effective. Information may include questionnaires, physical exams, or Written documentation as required by us. Evidence of insurability will be provided at our expense.

Good Cause means documented physical or mental impairments, which leave you unable to take part in or complete the agreed upon transitional work arrangement we developed.

We will review and consider your attending Physician's assessment; however, we reserve the right to make a good cause determination based on the medical opinion of our consulting Physician. If benefits are discontinued under this provision, you will have the right to an appeal review of that decision.

Gross Weekly Benefit means your benefit before any reduction for Deductible Sources of Income and any adjustment for Disability Earnings.

Hospital, Health Facility, or Institution means an accredited facility licensed according to state and local laws to provide care and treatment for the condition causing your disability. The facility must be supervised by one or more Physicians with 24 hour registered graduate nursing staff. The facility may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disorder. A facility specializing in treating alcoholism, drug addiction, chemical dependency or mental disorder does not include a rest home, convalescent home, and home for the aged or a facility primarily for custodial, educational, or rehabilitative care.

Injury means bodily injury resulting from an Accident, independent of disease, and not related to any other cause.

Insured Person means an Employee who is eligible for coverage and is the subject of insurance under the Certificates attached to the policy for which premium is paid.

Leave of Absence means you are absent from Active Employment for a period that has been agreed to by your Employer. Your normal vacation time or any period of disability is not considered a leave of absence.

Material and Substantial Duties means duties that:

- are normally required for the performance of your Own Occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work an average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Maximum Benefit means the total Weekly Benefit amount for which you are insured under the policy subject to all policy provisions.

Maximum Period of Payment means the longest period of time we will make payments to you for any one period of disability.

Occupational Sickness or Injury means a Sickness or Injury that was caused by or aggravated by any employment or self-employment for pay or profit. However, if Proof is provided to us that a claim has been made under any type of workers' compensation law and that no benefit, award, settlement, or redemption has been or will be made under such law for that Sickness or Injury, then that Sickness or Injury will not be considered an occupational sickness or an occupational injury.

Own Occupation means the occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed, and how the work tasks are performed for your Employer or at your specific location.

Part-Time Basis means the ability to work and earn 20% or more not to exceed 80% of your Weekly Earnings. Ability is based on capacity and not market availability.

Payable Claim means a claim for which we are liable under the terms of the policy.

Physician means a person performing tasks that are within the limits of his or her medical license; and

- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the Policy Situs state;
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must be certified and/or registered if required by jurisdiction.

We will not recognize you or your family members, including but not limited to, Spouse, domestic partner, child(ren), parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with you as a Physician for a claim that you send to us.

Policyholder means the entity to whom the policy is issued.

Prior Policy means the Policyholder's group short term disability insurance plan for which you were insured on the day prior to the effective date of our policy.

Proof means Written evidence satisfactory to us that a person has satisfied the conditions and requirements for eligibility for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, proof must establish:

- the nature and extent of the loss or condition;
- our obligation to pay the claim; and
- the claimant's right to receive payment.

Reasonable Accommodation means modifications or adjustments to a job, an employment practice or the work environment that makes it possible for a person with a disability to perform the Material and Substantial Duties of their occupation without causing undue hardship to any employer. It must meet federal standards of reasonable accommodation as defined by the Americans with Disabilities Act of 1991.

Reasonable Occupation means any gainful activity for which you are, or may reasonably become fitted by education, training, or experience which results in, or can be expected to result in an income of more than:

- 60% of your Weekly Earnings; or
- if less, the amount of the Maximum Weekly Benefit.

Recurrent Disability means a disability which is due to the same cause(s) as your prior disability for which we paid a Weekly Benefit.

Regular Care means:

- you personally visit in person or by telemedicine a Physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conform with generally accepted, medical standards, for your disabling condition(s) by a Physician whose specialty or experience is the most appropriate for your disabling conditions(s) according to generally accepted medical standards.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to Employees and are not funded entirely by Employee contributions. Retirement plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

Salary Continuation or Accumulated Sick Leave means continued payments to you by your Employer of all or part of your Weekly Earnings, after you become disabled as defined by the policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all Employees covered under the policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins.

Sickness means illness, disease, or Complications of Pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic media, or other durable media and which is consistent with applicable law.

Spouse means your lawful spouse and any other person required to be covered as your spouse under the civil union, domestic partnership, marriage or other family or domestic relations laws, including the case law, of the state where the policy is delivered or issued for delivery.

If the policy and Certificate are delivered or issued for delivery in different states, the Certificate, if required, will comply with the applicable marriage laws, including marriage case law, of the state where the Certificate is delivered or issued for delivery and, if required, with the applicable civil union laws of such state, with respect to coverage available for marital relationships, or civil unions.

Third Party means any person or entity whose act or omission, in full or in part, caused you to suffer a disability for which benefits are paid or payable under this plan. Third party also includes your homeowner's, automobile, or other insurance company if they make payments to you because of the acts or omissions of another person or entity.

Waiting Period means the continuous period of time (shown in the *Schedule of Benefits*) that you must be in Active Employment in an Eligible Class before you are eligible for coverage under the policy.

We, Us, and Our *(with or without initial capital letters)* means Continental American Insurance Company.

Weekly Benefit means your benefit after any Deductible Sources of Income and Disability Earnings have been subtracted from your Gross Weekly Benefit.

Weekly Earnings means your gross weekly income from your Employer as stated in the *Schedule of Benefits*.

Written or In Writing means a record which is on or transmitted by paper, electronic media, or other durable media and which is consistent with applicable law.

You, Your *(with or without initial capital letters)* means the Certificateholder:

- who is a member of an Eligible Class;
- who is eligible for benefits;
- for whom premium has been paid while covered under the policy; and
- who has received a Certificate.

GENERAL PROVISIONS

Entire Contract

This insurance is provided under a contract of group disability insurance with the Policyholder. The entire contract with the Policyholder consists of:

- all policy provisions and any amendments and endorsements to the policy;
- this Certificate and any amendments and endorsements to this Certificate;
- the Policyholder's Signed application.

Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Certificate of Coverage

This Certificate of Coverage is a Written statement prepared by us and may include attachments. It tells you:

- the coverage to which you may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions and requirements that apply within the policy.

No benefits are payable under this Certificate in the absence of payment of current premiums subject to the grace period and the *Premium* section of the policy. Unless specifically provided for in any applicable termination or continuation of coverage provision described in this Certificate or under the terms of the policy, this plan does not pay benefits for a disability incurred before coverage starts under this plan. This plan will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this plan as specifically provided under the terms of the policy or at renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits apply) to any losses incurred that start on or after the effective date of the plan modification. There are no vested rights to receive any benefits described in the policy or in this Certificate beyond the date of termination or renewal including if the loss, Accident, or disability starts on or after the effective date of the plan modification, but prior to your receipt of amended plan documents. If the policy ends, it will not affect a claim otherwise payable under the Certificate.

Incontestability

We consider any statement made by you a representation and not a warranty. No statement made by you will be used to reduce or deny any claim or to terminate your coverage unless:

- the statement is In Writing on an Evidence of Insurability form that is Signed by you; and
- a copy of that statement is given to you, your eligible survivor, or legally authorized representative.

No statement made by you relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years. For any applied or increased in coverage or reinstatement of coverage, a new two-year contestability period is applicable to the amount of the applied for increases, or reinstated coverage. Fraudulent statements will be used to contest the insurance for which the fraudulent statement was made when permitted by applicable law in the state where this Certificate is delivered or issued for delivery.

No statement made by you will be used to contest the insurance under the policy unless the statement is material to the risk accepted by us.

Clerical Error

Clerical error or omission by us or the Policyholder will not:

- prevent you from receiving coverage, if you are entitled to coverage under the terms of the policy; or
- cause coverage to begin or continue for you when the coverage would not otherwise be effective; or
- continue benefit payments under the policy that otherwise should validly terminate.

If we or the Policyholder make a clerical error in keeping data that is required to compute premiums and administer the terms of the policy, we will:

- use the facts to decide whether you have coverage under the policy and in what amounts; and
- make a fair adjustment of the premium.

Misstatement of Age

If premiums applicable to you are based on age and you have misstated your age, there will be a fair adjustment of premiums based on your true age. If the benefits applicable to you are based on age and you have misstated your age, there will be an adjustment of said benefits based on your true age. We may require satisfactory Proof of your age before paying any claim.

Workers' Compensation or State Disability Insurance

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Agency

For purposes of the policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

Non-Dividend Paying Policy

The policy is not entitled to share in surplus distribution.

Termination or Amendment of the Policy

If a disability for which Weekly Benefits are payable begins while your coverage under the policy is in force, benefits will be payable after termination of your coverage to the same extent as if the coverage had not terminated.

ELIGIBILITY

Eligibility Class:

You may only become eligible for the insurance available if you are a member of an Eligible Class shown in the *Schedule of Benefits*. **Refer to the *Schedule of Benefits* or contact your Employer to determine if you are in an Eligible Class.**

When Are You Eligible for Coverage?

If you are in Active Employment, the date you are eligible for coverage is the later of:

- the Policy Effective Date;
- your date of hire;
- the date you enter an Eligible Class; or
- the day after you complete your Waiting Period.

If you have already satisfied the Waiting Period with the Policyholder before you enter the Eligible Class, your Eligibility Date is the date you enter the Eligible Class.

What is a Waiting Period?

Once you enter an Eligible Class, you will need to complete the Waiting Period before your coverage under this plan begins. The Waiting Period is the continuous length of time that you must be in Active Employment and in an Eligible Class before you are eligible for coverage under this plan. This period begins on the date you enter an Eligible Class and ends on the date you complete the Waiting Period that applies to such insurance.

The Waiting Period is shown on the *Schedule of Benefits* for each Eligible Class.

Except as noted in the *Reinstatement* provision, if you terminate this insurance and later wish to reapply, or if you are a former employee who is rehired, a new Waiting Period must be satisfied.

Enrollment

Contributory Plan: Newly eligible persons may be enrolled for insurance under the policy up to 31 days of initial eligibility through the end of that month. This is your eligibility period. If you are required to enroll for insurance, you will need to enroll within this eligibility period.

For Contributory insurance you must contribute toward the cost. You may enroll by completing the enrollment process as instructed by the Policyholder. The Policyholder will provide the forms needed to enroll.

Late Applicant Enrollment Requirements

If you do not enroll for coverage within your eligibility period but wish to do so later, your Employer will provide you with information on when and how you can enroll as a late applicant.

You may not enroll until your Employer's next enrollment period or after a Life Status Change.

You must complete and submit Evidence of Insurability to us. We will review the information and solely determine your Eligibility Date. We will notify you and your Employer of our decision.

Effective Date of Your Insurance

Subject to the requirements of the section below entitled *Deferred Effective Date*, your insurance will become effective as determined in this section if you are in Active Employment on the date coverage would take effect. If you are not in Active Employment on the date coverage is to take effect, your effective date of coverage will be determined in the section below entitled *Deferred Effective Date*.

1. Coverage for eligible persons insured under the Prior Plan will be effective on the Policy's Effective Date.
2. For persons, who were not insured under the Prior Plan, and all new or newly eligible persons, coverage under the policy will become effective as described below:

   Contributory Plan will become effective the later of:

   - the date you become eligible for insurance for any amount of insurance that does not require Evidence of Insurability, if you apply on or before that date;
   - the date you apply for insurance for any amount of insurance that does not require Evidence of Insurability, if you apply within 31 days of initial eligibility through the end of that month;
   - the date for which the first premium for your coverage is paid;
   - the Policy Effective Date;
   - the date the enrollment period ends or the date the next plan year begins following the date you apply, if you apply during the enrollment period as defined by the Policyholder;
   - the date the next plan year begins following the date you apply, if you apply during the enrollment period as defined by the Policyholder; or
   - the date we state In Writing that your Evidence of Insurability been approved for any amount of insurance that requires you to give Evidence of Insurability.

Deferred Effective Date

Unless otherwise stated in the section entitled *Continuity of Coverage*, if you are not in Active Employment on the day before:

- the Policy Effective Date;
- the scheduled effective date of your insurance; or
- an increase in your insurance.

Your insurance, or an increase, will not become effective until the day after you return to Active Employment.

When Evidence of Insurability Is Required

If you are required to submit Evidence of Insurability, you must:

- complete and sign a health and medical history form provided by us;
- submit to a medical examination, if requested;
- provide any additional information that we require including verification of earnings and attending Physicians' statements; and
- furnish all such evidence at our expense.

Evidence of Insurability is required if:

- you re-enroll for coverage after your coverage ends for any reason;
- you apply to increase your Weekly Benefit by more than 1 increment during an enrollment period;

- you are a late applicant, which means you apply for coverage more than 31 days of initial eligibility through the end of that month;
- you voluntarily terminated your coverage and are reapplying;
- your coverage was terminated because you did not make the required Contributions;
- you have not met a previous evidence requirement to become insured under any plan the Employer has with us.

The Policyholder may not waive the Evidence of Insurability requirement for any reason.

If you do not give us evidence of your insurability, or if such Evidence of Insurability is not approved by us, the amount of your Weekly Benefit will not be more than the Weekly Benefit amount that does not require Evidence of Insurability.

CHANGING YOUR COVERAGE

When May You Elect to Change Your Coverage?

You will need to contact your Employer to determine when you may increase or decrease your coverage. Your Employer will provide you with information and forms you need to initiate the process. Your Employer will notify us of the date of the change.

You may elect to make changes to the options in your coverage during your Employer's enrollment period, or within 31 days of a Life Status Change. You must request the changes on a form approved by your Employer and us, and agree to pay the required premium Contributions, if any. Your request must be approved by us.

If a change results in an increase in the amount of your insurance and you are required to give evidence of your insurability satisfactory to us for such increase, you must give us such evidence.

If we approve an increase in the amount of your insurance, it will take effect on the date we state In Writing, if you are in Active Employment in an Eligible Class on such date. If you are not in Active Employment in an Eligible Class on such date, the increase will take effect on the date you resume Active Employment. If you are not approved for an increase, your coverage will automatically remain at the same level you had prior to applying for the increase.

When Will Changes to Your Coverage Take Effect?

Effective Date for Benefit Changes During an Enrollment Period

Changes you make during an enrollment period will become effective on:

- the next Policy Anniversary Date for any amount of insurance that is not subject to Evidence of Insurability requirements; or
- the first of the month coincident with or next following the date we approve Evidence of Insurability for any amount of insurance that is subject to Evidence of Insurability.

Effective Date for Benefit Changes Due to A Change in Earnings

Effective Date for Benefit Changes Due to A Change in Earnings

A change in your Weekly Benefit due to a change in your Weekly Earnings will be effective on the first of the month next following the date of the change, if you are in Active Employment. If you are not in Active Employment due to an Injury or Sickness, any increased or additional coverage will begin on the date you return to Active Employment.

Effective Date for Benefit Changes Due to a Change in Your Eligible Class

A change in your Weekly Benefit due to a change in your Eligible Class will be effective on the first of the month next following the date of the change, if you are in Active Employment. If you are not in Active Employment, any increased or additional coverage will begin on the date you return to Active Employment.

Effective Date for Benefit Changes by Policy Amendment

A change in your Weekly Benefit due to a change in the policy by an amendment elected by the Policyholder, will be effective on the date of the change, if you are in Active Employment. If you are not in Active Employment on the date a benefit payable change would otherwise be effective, any increased or additional coverage will begin on the date you return to Active Employment.

A change in your benefit payable because of a change made by us will normally be effective on the Policy Anniversary Date, or otherwise determined by state or federal law, or by us. However, if you are not in Active Employment on the date a benefit payable change would otherwise be effective, the benefit payable change will not

be in force until you return to Active Employment.

Effective Date of a Benefit Decrease

Any decrease in coverage will take effect immediately upon the effective date of the change.

Effect of a Change in Coverage on a Payable Claim

Neither an increase nor a decrease in coverage will affect a Payable Claim that occurs prior to the increase or decrease.

Life Status Changes

You may elect to enroll or increase coverage within 31 days after a Life Status Change. A Life Status Change is an event that qualifies you to make changes in benefit selections at a time other than an enrollment period. To elect or change coverage you must enroll. If required you must also submit Evidence of Insurability, satisfactory to us. We will review the information and determine your eligibility. We will notify you and your Employer of our decision.

The following events are Life Status Changes:

- marriage;
- divorce, annulment, or legal separation;
- birth or adoption of a child, or becoming a legal guardian of a child;
- death of a Spouse;
- termination of a Spouse's employment;
- a change in the benefit plan available to your Spouse;
- a change in your classification from part-time to full-time, or from full-time to part-time;
- a change in you or your Spouse's employment status that affects either person's eligibility for benefits; or
- any other changes required to be treated as Life Status Changes by law.

A change in insurance due to a Life Status Change will be effective the latest of:

- the date of the change in status, if you apply on or before that date;
- the date you apply, if you apply within the eligibility period; or
- the date we state In Writing that we approved any required Evidence of Insurability.

You must be in Active Employment on the date a Life Status Change becomes effective. If you are not in Active Employment on the date insurance would become effective, the *Deferred Effective Date* provisions will apply.

CONTINUITY OF COVERAGE

Transferred Coverage from a Prior Plan to This Plan

This provision provides continuity of coverage when you are in Active Employment when the Policyholder transfers prior group insurance to this plan, or by an Employer which has merged with or otherwise combined with the Policyholder. If your coverage under the policy replaces any prior coverage that you had, the following rules apply.

What If You Are Not in Active Employment When Your Employer Replaces Insurance Coverage with Our Policy?

If you are not in Active Employment due to Injury or Sickness on the date your Employer changes insurance carriers to our policy, and you were covered under the Prior Policy at the time your Employer's coverage under our policy became effective, we will provide continuity of coverage under our policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our policy.

If you are not in Active Employment due to Injury or Sickness on the effective date of our policy, and you would otherwise be eligible to become insured under our policy, we will provide Limited Coverage under our policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of:

- the date you return to Active Employment; or
- the end of any period of continuance or extension provided under the Prior Policy.

If you are not in Active Employment due to Leave of Absence or Temporary Layoff on the date your Employer changes insurance carriers to our policy, and you were covered under the Prior Policy at the time your Employer's coverage

under our policy became effective, we will provide continuity of coverage under our policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our policy.

If you are not in Active Employment due to Leave of Absence or Temporary Layoff on the effective date of our policy, and you would otherwise be eligible to become insured under our policy, we will provide Limited Coverage under our policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of:

- the date you return to Active Employment; or
- the end of any period of continuance or extension provided under the Prior Policy; or
- the date coverage would otherwise end, according to the provisions of our policy.

Your coverage under this provision is subject to payment of premium.

For the purposes of this provision the following definition applies:

> ***Limited Coverage*** **means benefits payable will be paid as if the Prior Policy had remained in effect and you continued to be insured under that policy. We will reduce your payment by any amount for which the prior carrier is liable.**

If coverage ends under this provision, or if you were not covered under your Employer's Prior Policy of the date that policy terminated, the *Effective Date of Your Insurance* provision will apply.

How Does the Pre-Existing Condition Work If You Were Covered Under Your Employer's Prior Plan?

You may be eligible for a Weekly Benefit if your disability results from a Pre-Existing Condition if you were:

- in Active Employment and insured under the plan on its effective date; and
- insured by the Prior Policy at the time of change.

In order to receive a Weekly Benefit, you must satisfy a *Pre-Existing Condition* provision under:

1. our plan; or
2. the prior carrier's plan if benefits would have been paid had that policy remained in force.

If you do not satisfy item 1 or 2 above, we will not pay benefits under our plan.

If you satisfy item 1, we will determine your benefits according to our plan provisions.

If you only satisfy item 2, we will administer your claim according to our plan provisions. However, your Weekly Benefit will be the lesser of:

- the Weekly Benefit that would have been payable under the terms of the Prior Policy if it had remained in force; or
- the Weekly Benefit under our plan.

Your benefits will end on the earlier of the following dates:

- the end of the Maximum Weekly Benefit under this plan; or
- the date benefits would have ended under the Prior Policy if it had remained in force.

If You Have a Disability Due to a Prior Disability After Your Employer Replaces Insurance Coverage with Our Policy (Credit for a Prior Disability)

You do not have to complete the Elimination Period under this plan if, after your disability ended under the Prior Policy for which you received a disability benefit, you:

- are not eligible for successive benefits under your prior carrier's policy; and
- returned to work for your Employer for 14 consecutive days or less; and
- become disabled under the terms of this plan due to the same cause(s) as your prior disability.

We will require Proof that you received disability benefits for the prior disability under the Prior Policy. All other provisions of our policy will apply.

When Continuity of Coverage Ends

You will remain covered under this *Continuity of Coverage* provision until the first to occur:

- the date you return to Active Employment at which time insurance in effect under the policy will not be subject to Prior Plan provisions or benefit limitations;
- the last day of a period of 12 consecutive months which begins on the Policy Effective Date, at which time coverage under the policy will also end;
- the date insurance would otherwise end for you in accordance with the terms and conditions of this Certificate, at which time coverage under the policy will also end;
- the date on which insurance would have ended under the Prior Plan, had the Prior Plan not terminated at which time coverage under the policy will also end; or
- if the Prior Plan provided for extension of insurance without premium payment during a period of disability, on the earliest of:
    (a) the date you are approved for such benefit under the terms of the Prior Plan;
    (b) the last day of the 12-month period following our Policy's Effective Date; and
    (c) coverage under our policy will also end.

Duplication of Coverage

If you qualify for benefits under the Prior Plan such that a duplication of coverage situation exists after coverage begins under the policy, you must exercise your rights under the Prior Plan and duplicate benefits will not be payable under the policy.

Coverage under the policy will not take effect if your coverage under the Prior Plan is continued under any disability provision or you have enrolled in a conversion plan option with the Prior Plan.

Premium Payments

Premium payments are required for all Insured Persons during the period continuity of coverage under this provision is in effect. We will not waive premium during the period coverage is continued.

CONTINUATION OF COVERAGE BY THE POLICYHOLDER

When Will Your Coverage Continue If You Are Temporarily Not Working?

The Policyholder has elected to continue your insurance for any of the reasons specified below. Premium for the continuation period must be paid on the same basis as premium was paid on the day before your Sickness or Injury began.

If You Are Not in Active Employment Due to Leave of Absence

If you are on an Employer approved Leave of Absence, and if premium is paid, you will be covered for 12 months that immediately follows the date in which your Leave of Absence begins.

Continuation of Coverage While on A Family and Medical Leave of Absence

We will continue your coverage in accordance with the Policyholder's policy on family and medical leaves of absence if premium payments continue and the Policyholder approved your leave In Writing.

If you were granted a Leave of Absence according to the "Family and Medical Leave Act of 1993", your coverage will continue under this provision for the balance of your leave.

Coverage will be continued until the end of the later of:

- the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
- the leave period required by applicable national, state, or local law, or any similar law, plan, or act.

If the Policyholder's policy does not provide for continuation of your coverage during a family and medical leave of absence, your coverage will be reinstated when you return to Active Employment.

If you return to work immediately following your leave, we will not:

- apply a new Waiting Period; or
- apply a new Pre-Existing Conditions exclusion.

Continuation of Coverage While on Leave During Military Service

We may continue your insurance, if applicable, in accordance with the Policyholder's policies regarding Leave of

Absence for military service under the Uniformed Services Employment and Reemployment Act (USERRA) and applicable state law. Premiums must be paid for continued coverage for you. Coverage may be continued until the end of the period required by USERRA. If your coverage is not continued during a Leave of Absence for active military service, and you return to Active Employment, your coverage shall be reinstated in accordance with USERRA and applicable state law.

Concurrent Leaves

If your Employer has approved more than one type of Leave of Absence for you during any one period that you are not in Active Employment, we will consider such leaves to be concurrent for the purpose of determining how long your coverage may continue under the policy.

End of a Continuation Period

Continuation insurance will end on the earliest of the following:

- the date your continuation leave ends;
- the date the Policyholder ceases to pay your premiums, or otherwise terminates your insurance;
- the maximum continuation period has been reached; or
- the date the policy or this plan terminates.

At the end of any of a continuation period if you resume Active Employment in an Eligible Class you will continue to be covered under the policy.

If you do not resume Active Employment in an Eligible Class at this time, your employment will be considered to end, and all insurance will end in accordance with the provision *When Does Your Coverage End*.

In no event will your coverage under the policy be continued beyond the date your coverage would otherwise end according to the terms of the *When Does Your Coverage End* provision.

DATE COVERAGE ENDS AND REINSTATEMENT

When Does Your Coverage End?

Your coverage under this plan ends on the earliest of:

- the date the policy or the plan is terminated;
- the date you voluntarily stop your coverage;
- the date you are no longer in an Eligible Class;
- the date you are no longer eligible for coverage;
- the last day of the period for which you made any required Contributions; (Only the coverage for which you failed to make required Contributions will be terminated);
- the date your employment stops for any reason, including job elimination, or being placed on severance. This will be the date you stop Active Employment;
- the date your Eligible Class is no longer covered;
- the last day you are in Active Employment except as provided under the section *Continuation of Coverage By The Policyholder* provision;
- the date on which you retire; or
- the date on which you begin active duty in the armed forces of any country.

Reinstatement of Contributory Coverage

If your coverage ends, you may apply to reinstate coverage subject to the rules described below.

To apply for reinstatement of your coverage you must submit:

- Written application to us on a form provided by us;
- Evidence of Insurability including good health satisfactory to us; and
- payment of all overdue premiums.

You must be in an Eligible Class and in Active Employment. The Policyholder must provide a Written request for reinstatement within 30 days from the date you return to Active Employment.

If we approve your request, you will be notified of your reinstatement date.

The amount of insurance reinstated will be the lesser of the amount of insurance you previously had upon termination of your coverage, or the maximum amount available for your Eligible Class on the date of reinstatement, unless:

- your Evidence of Insurability is not satisfactory to us;
- you have not paid all overdue premiums;
- you are not in an Eligible Class; or
- the policy or this plan has been terminated.

If you return to Active Employment within 6 months of the date your coverage terminated and you request coverage from your Employer within 30 days of your return, the Pre-Existing Condition limitation and the Waiting Period requirement will apply only to the extent they would have applied if your coverage had not ended.

If you were previously insured under the policy and your insurance terminated for a reason other than termination of your payroll deduction, and you later become employed in an Eligible Class within 6 months after your insurance terminated under this Certificate, any Waiting Period will be waived for you.

SHORT TERM DISABILITY BENEFIT INFORMATION

How Do we Define a Short Term Disability?

You are considered to be disabled if, solely and directly because of a Sickness or Injury, all of the following applies:

- you must be covered by this plan at the time you become disabled;
- you must be under the Regular Care of a Physician for your Sickness or Injury; and
- the Sickness or Injury is not an Occupational Sickness or Injury; and
- you must meet the conditions of disability below.

You are disabled when it is determined that due to your Sickness or Injury:

- you are unable to perform one or more of the Material and Substantial Duties of your Own Occupation; and
- you have a 20% or more loss in your Weekly Earnings.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your Physicians and Physicians and medical practitioners or vocational experts of our choice.

We may require you to be examined by a Physician, other medical practitioner and/or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by our authorized representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Elimination Period

How Long Must You Be Disabled Before You Are Eligible to Receive Benefits?

The Elimination Period is the period of continuous disability you must satisfy before you are eligible to receive benefits under the policy. You must be continuously disabled through your Elimination Period. Your Elimination Period is as stated in the *Schedule of Benefits*. The days that you are not disabled will not count toward your Elimination Period.

The Elimination Period begins on the first day of your disability. If your disability stops during the Elimination Period, we will not consider your disability to be continuous.

No benefit is payable for or during the Elimination Period. You must be under the care of a Physician during the Elimination Period. Benefits for a Payable Claim begin the day after the Elimination Period is completed.

Can You Satisfy Your Elimination Period If You Are Working?

Yes. If you are working while you are disabled, the days you are disabled will count toward your Elimination Period.

When Will You Begin to Receive Benefits?

The benefit payable is the Weekly Benefit shown in the *Schedule of Benefits*. The Weekly Benefit is based on your Weekly Earnings.

You will begin to receive benefits when your claim is approved, providing the Elimination Period has been satisfied, you are under the Regular Care of a Physician, and you are disabled as defined in this Certificate. We will send you

a Weekly Benefit for any period for which we are liable but not beyond the Maximum Period of Payment shown in the *Schedule of Benefits*. No benefit is payable during the Elimination Period.

After the Elimination Period, if you are disabled for less than 1 week, we will send you 1/7th of your Weekly Benefit for each day of your disability.

If you are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by your Employer or you were terminated before the effective date of this plan, then no benefits will be payable for the disability under the policy.

What Is the Maximum Period of Payment?

You will receive a benefit for each week you remain disabled, up to the Maximum Period of Payment. Your Maximum Period of Payment is described in the *Schedule of Benefits*.

Recurrent Disability

If you return to Active Employment and you have a Recurrent Disability, we will treat your disability as part of your prior claim, and you will not have to complete another benefit Elimination Period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your Recurrent Disability; and
- your Recurrent Disability occurs within 14 consecutive days from the end of your prior claim and your return to Active Employment.

Your Recurrent Disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability, which occurs after 14 consecutive days from the date your prior claim ended, will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the Elimination Period.

How is Your Benefit Determined?

How Is Your Benefit Determined When Not Working?

We will follow this process to calculate your benefit amount:

1. Multiply your Weekly Earnings by the Weekly Benefit percentage shown in the *Schedule of Benefits*.
2. The Maximum Weekly Benefit is listed in your *Schedule of Benefits*.
3. Compare the answer from item 1 with the Maximum Weekly Benefit. The lesser of these two amounts is your Gross Weekly Benefit.
4. Subtract any Deductible Sources of Income from your Gross Weekly Benefit.

The amount figured in item 4 is your Weekly Benefit. The Weekly Benefit will be recalculated when you receive any new Deductible Sources of Income.

How is Your Benefit Determined if You Are Disabled and Working?
Work Incentive Benefit

If you are disabled and return to work, we will not reduce your Weekly Benefit for Disability Earnings if your weekly Disability Earnings are less than 20% of your Weekly Earnings.

If you are disabled and your weekly Disability Earnings are 20% or more of your Weekly Earnings, we will calculate your Weekly Benefit as follows:

1. Add your weekly Disability Earnings and Deductible Sources of Income, if any to your Gross Weekly Benefit.
2. Compare the answer in item 1 to your Weekly Earnings.

If the answer from item 1 is less than or equal to 100% of your Weekly Earnings, we will not further reduce your Weekly Benefit.

If the answer from item 1 is more than 100% of your Weekly Earnings, we will subtract the amount over 100% from your Weekly Benefit.

Total Benefit:

The total benefit payable on a weekly basis (including all benefits provided under this plan), will not exceed 100% of your Weekly Earnings unless otherwise stated in this Certificate under the specific conditions stated.

How is the Weekly Benefit Calculated if Disability Earnings Fluctuate?

If your weekly Disability Earnings routinely fluctuate widely from week to week, we may average your Disability Earnings over the most recent 12 weeks to determine if your claim should continue.

If we average your Disability Earnings, we will not terminate your claim unless the average of your Disability Earnings exceeds 80% of your Weekly Earnings.

We will not pay you for any week during which Disability Earnings exceed the above amounts. The Minimum Weekly Benefit will not be paid when Disability Earnings exceed the above amounts. In no event will benefits be paid beyond the Maximum Period of Payment.

What Are Deductible Sources of Income and How Do They Affect My Benefits?

Deductible Sources of Income are other income benefits you, your Spouse or child may be entitled to receive because of your disability or retirement. These benefits are taken into consideration when your Weekly Benefit is calculated and may reduce your Weekly Benefit.

We will only subtract Deductible Sources of Income which are payable as a result of your disability, with the exception of retirement payments, amounts earned or received from any form of employment and amounts received from any unemployment compensation law.

We will subtract from your Gross Weekly Benefit the following Deductible Sources of Income:

1. The amount that you receive or are entitled to receive under:
   - any state or federal occupational disease or injury law;
   - any other plan, act, or law, with similar intent.
2. The amount that you, your Spouse, and children receive or are entitled to receive as disability benefits under any:
   - state compulsory benefit act or law;
   - income payments under no fault motor vehicle plan;
   - other group insurance plan to the extent that such policy or plan covers the same pre-disability income;
   - governmental retirement system as a result of your job with your Employer.
3. The gross amount that you, your Spouse, and children receive or are entitled to receive as disability benefits because of your disability under:
   - the United States Social Security Act;
   - the Canada Pension Plan;
   - the Railroad Retirement Act;
   - any similar plan, act, or law, of any country, state, or province.

   Amounts paid to your former spouse or to your children living with such spouse will not be included.
4. The gross amount that you receive as retirement payments or the amount your Spouse and children receive as retirement payments because you are receiving retirement payments under:
   - the United States Social Security Act;
   - the Canada Pension Plan;
   - the Railroad Retirement Act;
   - any similar plan, act, or law, of any country, state, or province.

   This does not include benefits for any month before you reach normal retirement age, as defined under the Social Security Act, unless you choose to receive these benefits.

   Benefits paid to your former spouse or your children living with such spouse will not be included.
5. The amount that you:
   - receive as disability benefits under your Employer's Retirement Plan;
   - voluntarily elect to receive as retirement benefits under your Employer’s Retirement Plan;
   - receive as retirement benefits when you reach the later of age 62 or normal retirement age, as defined in your Employer's Retirement Plan.

   Disability payments under a Retirement Plan will be those benefits which are paid due to a disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement benefits will be those benefits that are paid based on your Employer's contribution to

the Retirement Plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, we will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible Retirement Plan as defined in section 402 of the Internal Revenue Code including any future amendments that affect the definition.

6. Third Party payments, damages, settlements, or judgments received for lost income for your disability (after subtracting attorneys' fees). If the amount received from the Third Party does not specify the lost income amount, we will estimate the amount using a percentage of the settlement amount based on the Insured Person's Weekly Earnings, prorated to cover the period for which the settlement or judgment was made. If your disability benefit is reduced because of 1) other benefits or income for amounts received minus legal fees, or 2) for lost income due to a disability because of omission of the Third Party, the claim will not be subject to subrogation.
7. The amount you receive under Title 46, United States Code Section 688 (The Jones Act) and the Doctrine of Unseaworthiness.
8. The amount you receive under the Admiralty and Maritime Law, maritime doctrine of maintenance, wages, and cure. This includes only the "wages" part of such benefits.
9. Disability benefits received under state disability benefit plans and state family leave benefits, where permitted by state law.
10. Another group disability income policy or plan to the extent that such policy or plan covers the same pre-disability income.
11. The amount of loss of time benefits that you receive or are entitled to receive under any Salary Continuation and Accumulated Sick Leave.
12. The amount that you receive from a partnership, proprietorship, or any similar draws.
13. The amount you receive from franchise disability plans to the extent that cumulative benefits payable would exceed Weekly Earnings.
14. The amount you receive or are entitled to receive under any unemployment income act or law due to the end of employment with your Employer or payable by insured and uninsured plans or as a result of your membership or association in any group, union, or other organization.

With the exception of retirement payments, or amounts that you receive from a partnership, proprietorship, or any similar draws, we will only subtract Deductible Sources of Income which are payable as a result of your disability.

We will not reduce your payment by your social security retirement income if your disability begins after age 65 and you were already receiving social security retirement payments.

What Are Not Deductible Sources of Income?

We will not subtract from your Gross Weekly Benefit income you receive from, but not limited to, the following:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- individual retirement accounts (IRA);
- individual disability income plans paid for by you;
- 457 deferred compensation plans;
- 403(b) tax sheltered annuity plans;

- retirement benefits from a former employer;
- social security widow's benefits.

What Happens When You Receive a Cost of Living Increase From Deductible Sources of Income?

Once we have subtracted any Deductible Sources of Income from your Gross Weekly Benefit, we will not further reduce your Weekly Benefit due to a cost of living increase from that source.

What If We Determine You May Qualify for Deductible Income Benefits?

If your disability may qualify for benefits in the *Deductible Sources of Income* section, we will estimate your entitlement to these benefits. We can reduce your Weekly Benefit by the estimated amounts if such benefits:

- have not been awarded or received; and
- have not been denied; have been denied, and the denial is not being appealed, if appeal rights are provided.

Your Weekly Benefit may not be reduced by the estimated amount if you:

- apply for the benefits in the *Deductible Sources of Income* section, and appeal your denial to all administrative levels we feel are necessary; and
- sign our reimbursement agreement form. This form states that you promise to pay us any overpayment caused by an award.

If your benefit has been reduced by an estimated amount, your benefit will be adjusted when we receive Proof:

- of the amount awarded; or
- that benefits have been denied and all appeals we feel are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

We will not estimate your entitlement to the following:

- payments you receive as disability payments under your Employer's Retirement Plan;
- payments you voluntarily elect to receive as retirement payments under your Employer's Retirement Plan;
- payments you are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's Retirement Plan;
- the amount you receive as disability payments under any "no fault" motor vehicle plan; or
- the amount you receive from a Third Party (after subtracting attorneys' fees) by judgment, settlement or otherwise as disability payments.

What Happens If You Receive a Lump Sum Payment?

If you receive a lump sum payment from any Deductible Sources of Income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one. If any part of the lump sum payment dates back to a prior date it may be allocated on a retroactive basis. We will prorate the lump sum payment over your remaining benefit period.

What is the Minimum Weekly Benefit?

If your Weekly Benefit is reduced to zero due to subtracting Deductible Sources of Income, you will receive a Minimum Weekly Benefit. Your Minimum Weekly Benefit is listed on the *Schedule of Benefits*.

We may apply your Minimum Weekly Benefit toward any outstanding overpayment.

The Minimum Weekly Benefit will not be paid in any week when Disability Earnings exceed 80% of your Weekly Earnings. This includes when we average your Disability Earnings as described above.

When Will Disability Benefits Stop or Not Be Paid?

When Will Disability Benefits Stop?

Your claim will end, and benefits will stop on the earliest of the following:

- the end of the Maximum Period of Payment;
- the date you are no longer disabled under the terms of the plan;
- the date when you are functionally able to work in your Own Occupation on a Part-Time Basis, increase your hours, or increase the number or type of duties you perform in your Own Occupation, but you choose not to;
- the date you fail to submit Proof of continuing disability;

- during a period, you are in legal incarceration or in a penal or correctional institution;
- your date of death;
- the date you retire; or
- the date any employer offers you another or modified job position, which Physicians agree you are able to functionally perform, at a pay rate that exceeds 80% of your Weekly Earnings.

When Will Disability Benefits Not Be Paid?

Disability benefits will not be paid for any period of disability during which you:

- are not following a plan of Regular Care for your disability, or complications of your disability. This includes effective treatment for alcoholism or drug abuse, if alcoholism or drug abuse is the cause (or part of the cause of your disability;
- are not receiving Regular Care;
- refuse to be examined by an independent Physician or a licensed certified health care practitioner as requested by us when provided at our expense;
- refuse to follow or have rejected the treatment plan recommended by your Physician, unless you dispute such treatment in good faith on the advice of another Physician;
- refuse a Reasonable Accommodation or modification to your worksite or a job process designed to suit identified medical limitations;
- refuse adaptive equipment or devices that would allow you to perform your Own Occupation or any Reasonable Occupation;
- refuse a transitional work arrangement or other modified work arrangement without Good Cause;
- during a period, you are in legal incarceration or in a penal or correctional institution;
- fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due; or
- refuse to interview with our representative about your disability.

If you become covered under another group disability income policy or plan to the extent that such policy or plan covers the same pre-disability income, you will not be eligible for benefits under this disability plan.

EXCLUSIONS AND LIMITATIONS

Disabilities Not Covered under the Policy

The policy does not cover any disabilities caused by, contributed to by, or resulting from your:

- a Pre-Existing Condition;
- commission or attempt to commit a felony;
- intentionally self-inflicted harm;
- attempted suicide;
- Loss of License - professional/occupation license/certificate
- loss or death occurring while an Insured Person is incarcerated;
- operating a motor vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit;
- war, declared or undeclared, or any act of war, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
- active participation in a riot, act of insurrection, rebellion or civil commotion, or act of terrorism;
- engaging in any illegal occupation, work, employment or activity;
- cosmetic surgery except when required for your Regular Care as a result of your Sickness or Injury; cosmetic surgery does not include:
  - reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly resulting in a functional defect; or
  - if the disability is caused by your donation of an organ in a non-experimental organ transplant procedure;

- Occupational Sickness or Injury;
- Sickness or Injury for which workers' compensation benefits are paid, or may be paid if duly claimed;
- Injury sustained as a result of doing any work for pay or profit for another employer;
- Sickness or Injury for which workers' compensation benefits are paid, or may be paid if duly claimed;
- hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing; or
- traveling in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger.

What Is a Pre-Existing Condition?

You have a Pre-Existing Condition if both 1 and 2 are true:

1. you received medical treatment, consultation, care, or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage or the date and increase in benefits through amendment or your enrollment in another plan option, would otherwise be available; and
2. You have been continuously insured under The Policy or another subsidiary of the parent company for 12 consecutive month(s).

The Pre-Existing Condition exclusion does not apply to a Pre-Existing Condition for which You had a Treatment Free Period for a disability which begins in the first 3 months of coverage.

If the disability is the result of a Pre-Existing condition, the Maximum benefit is 4 weeks.

Free Period is a period of time after the coverage effective date in which no charges were incurred or treatment was rendered, except for maintenance drugs prescribed for a previous condition and for which You are asymptomatic, for the Pre-Existing Condition, and the insured had no symptoms for which an ordinarily prudent person would have consulted a health care provider. The Treatment Free Period is 3 months.

CLAIM INFORMATION

Notice of Claim

We encourage you to notify us of your claim as soon as possible. This will help us make a claim decision in a timely manner. Written notice of a claim should be given to us within 30 days after the date your disability begins. Failure to give notice within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

Claim Forms

The claim form is available from your Employer, or you can request a claim form from us.

Within 15 days after we receive your notice of a claim, we will send claim forms. The claim form is also available from your Employer. If we do not send you the claim forms within 15 days after receiving notice of your claim, you shall be deemed to have complied with the requirements of Proof of claim when you submit Written Proof that covers the occurrence, character, and extent of the loss for which a claim is made.

Filing A Claim

You and your Employer must fill out your own sections of the claim form and then give it to your attending Physician. Your Physician should fill out his or her section of the form and send it directly to us.

Our customer service department will assist you to file your claim. Call the number in this Certificate.

Proof of Your Claim

You must send us Written Proof of your disability claim no later than 90 days after your Elimination Period ends. Your Proof of claim, provided at your expense, must show:

- that you are under the Appropriate Care of a Physician;
- the date your disability began as determined by your Physician;
- the cause of your disability;
- the appropriate documentation of your Weekly Earnings and Disability Earnings;
- the extent of your disability, including restrictions and limitations preventing you from performing your Own Occupation;
- the name and address of any Hospital, Health Facility, or Institution where you received treatment, including all attending Physicians; and
- documentation of prior disability coverage, if applicable.

For all other claims you must send us Written Proof no later than 90 days after the date of the last period.

Failure to give such Proof within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such Proof within that time, and the Proof was given as soon as reasonably possible. You must provide Proof of claim no later than 1 year after the time Proof is otherwise required, except in the absence of legal capacity.

You will be required to give us Written authorization to obtain additional medical information and to provide non-medical information such as vocational, occupational, financial, and governmental as part of your Proof of claim. We will deny your claim, if the appropriate information is not submitted within 45 days of the request.

Continuing Proof of Claim

We may require you to provide continuing Proof of your claim as often as it is reasonable to do so during the pendency of your claim. You will have 60 days from the date of our request to provide us with continuing Proof of your claim. Failure to provide continuing Proof of your claim shall not result in a reduction of your benefits, however your benefit payment may be delayed until the requested continuing Proof is provided. We may request that you provide us with Proof of continuing disability indicating that you are under the Regular Care of a Physician. You must provide continuing Proof of claim no later than 1 year after the time Proof is otherwise required, except in the absence of legal capacity. This Proof shall be In Writing and satisfactory to us.

You and your Employer must notify us immediately when you return to work in any capacity.

To Whom Payments Are Made

We will pay your benefits to you unless this Certificate specifies otherwise. If any amount for which we are liable remains unpaid when you die, we will pay that amount to your eligible survivor or, if none, to your estate. If, however, it is necessary for the establishment of a guardianship or conservatorship, or appointment of a trustee, executor or administrator, we may withhold further benefits until sufficient evidence is provided to us that any such establishment or appointment has been finalized. We will pay benefits within 30 days of receiving sufficient evidence of the establishment or appointment. If we pay benefits on or after the 31st day of receiving sufficient evidence, the delayed payment will be subject to a simple 10% interest rate per year, beginning with the 31st day and ending on the day benefits are paid.

Time Payment of Claims

Once your claim has been approved, we will send you a payment at the end of each week for any period for which we are liable. The first Weekly Benefit will be paid within 30 days of an approved claim. Any balance remaining unpaid by us upon termination. of such period for which we are liable will be paid within 30 days upon receipt of Proof of your claim. A delayed payment of your claim will be subject to a simple interest at a rate of 10% per year beginning on the 31st day after receipt of satisfactory Proof of your claim and ending on the day the claim is paid. Indemnities payable under the policy for any loss other than loss for which the policy provides periodic payments will be paid as they accrue immediately upon receipt of do Written Proof of such loss.

Authority

The Policyholder has delegated to the insurance company or its designee certain rights. These include the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and Certificate. This delegation is made for the purpose of claims and enrollment administration only. The insurance company is not the Plan Administrator, as defined by ERISA.

Physical Examination

We may require you to be examined by one or more Physicians, other medical practitioners, or vocational experts of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so during the pendency of a claim. We may also require you to be interviewed by our authorized representative. Your failure to comply with this request may result in denial or termination of benefits.

Refund of Unearned Premium

Any unearned premium will be refunded to the Policyholder or the Insured Person as applicable.

Claims of Creditors

Disability benefit payments are exempt from legal or equitable process for your debts, where permitted.

Right to Reimbursement

We have the right to recover any overpayment due to:

- fraud;
- any administrative error we make in processing a claim; or
- your receipt of Deductible Sources of Income.

You must reimburse us in full. If we find that we should have paid a benefit amount different from the amount actually paid, we will adjust the benefit accordingly. If we underpaid your benefit, then we will adjust the benefit to make up the underpayment. If we overpaid your benefit, you shall reimburse us. Any future benefits that are determined to be due, including any applicable minimum benefit, will be applied to the over payment until we are reimbursed in full. If future benefits are not due, we will determine the method by which the repayment is to be made.

You shall not act or fail to act in any manner that will prejudice our right to reimbursement without our prior Written agreement. If you prejudice our right to reimbursement, fail to cooperate with us or fail to comply with this provision, we may withhold any and all benefits in addition to pursuing all remedies available to us under applicable law.

If we pursue legal action against you to obtain reimbursement, you will be required to pay our costs and attorneys' fees as permitted by applicable law. We reserve the right to recover any prior or current overpayment not only from the amounts you receive as Deductible Sources of Income (to the extent permitted by applicable law) but also from any benefits from any past, current, or new disability claim payable under the policy as well as from any other funds you may have.

You must notify us if you make a claim against any Third Party. Neither you nor anyone acting on your behalf may settle your claim against the Third Party without our prior Written consent. If you recover amounts from a Third Party by award, judgment, settlement or otherwise, you must reimburse us for lost income due to a disability because of an act or omission of the Third Party. You must reimburse us regardless of whether you have been made whole by the recovery, subject to limitations under applicable law where the policy is delivered or issued for delivery. If the amount received from the Third Party does not specify the lost income amount, we shall estimate the amount using a percentage of the settlement amount based on your Weekly Earnings, prorated to cover the period for which the settlement or judgment was made. We shall have first right to reimbursement. The amount you reimburse us will be reduced by our pro rata share of your attorneys' fees and costs. If another entity is also entitled to reimbursement but does not reduce its reimbursement by its pro rata share of such fees and costs, then our pro rata share will be calculated as if that entity did make such reductions.

Right To Subrogation

If we have paid or will pay benefits in connection with a disability which you suffered because of an act or omission of a Third Party, we reserve any and all rights of recovery available to us under applicable law in the state where the policy is delivered or issued for delivery that you have against the Third Party to the extent necessary to protect our interests. We have the right to bring legal action against the Third Party on your behalf to recover the payments made by us if you do not initiate legal action for the recovery of such payments from the Third Party in a reasonable period of time. You must agree to furnish all information and documents that are necessary to secure our rights. We will pay for any expenses connected with our pursuit of subrogation or recovery. You shall not act or fail to act in any manner that will prejudice our right to subrogation without our prior Written agreement. If you prejudice our right to subrogation, fail to cooperate with us or fail to comply with this provision, we may pursue all remedies available to us under applicable law.

If we bring a legal action against the Third Party on your behalf, we will not reduce your disability benefits by any other amounts you receive from the Third Party.

How We Handle Insurance Fraud

We have the right and promise to use all means available to us to detect, investigate, deter, and prosecute those who commit insurance fraud. We shall have the right to pursue all legal remedies if you and/or your Employer perpetrate insurance fraud.

If you or the Policyholder knowingly and with intent to defraud or deceive us, provide us with false information or file a claim for benefits that contains any false, incomplete, or misleading information, or conceals for the purpose of misleading, information concerning any material fact.

You or the Policyholder may be guilty of a criminal offense and subject to penalties under state law.

Time Limits for Legal Proceedings

You can start legal action regarding your claim 60 days after Proof of claim has been given to us, and before the applicable statute of limitations has expired but not after 3 years from the date of Proof of claim is required unless otherwise provided under federal law.

CONTINENTAL AMERICAN INSURANCE COMPANY
P.O. Box 427 Columbia, South Carolina 29202 800.992.3522

APPLICABILITY OF ERISA

If this policy provides benefits under a plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply.

Information about Your ERISA Plan

The benefits are provided in a fully insured plan issued by Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, and are described in the Certificate of Coverage.

You have certain rights and protections under ERISA.

1. **The right to receive information about your plan and its benefits.**
    a. You have the right to review and the right to receive, free of charge, at the Plan Administrator's office (or in a place designated by the Plan Administrator all documents governing the plan, including but not limited to, insurance contracts or a copy of the latest annual report (Form 5500). The Form 5500 is filed by the plan with the U.S. Department of Labor (DOL) and is available in the Public Disclosure Room of the Employee Benefits Security Administration.
    b. You have the right to receive an annual summary of the plan's financial report.
2. **The right to prudent action by the Plan fiduciaries.**

    ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
3. **How to enforce your rights.**
    a. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
    b. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
    c. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. You are required to complete administrative appeals prior to filing in court. Your right to file suit in state or federal court may be affected if you do not complete the required appeals.
    d. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
4. **Need help?**
    a. If you have any questions about the plan, please contact the Plan Administrator.
    b. If you have any questions about your rights under ERISA, or if you need help getting documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA) or the Division of Technical Assistance and Inquiries, EBSA, U.S. Dept. of Labor, 200 Constitution Ave. N.W., Washington, DC 20210.
    c. Certain publications about your ERISA rights and responsibilities can be found by calling the EBSA publications hotline or visiting dol.gov/ebsa.

Claim Procedures

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance Certificate. To complete your claim filing, we must receive the claim information requested from you (or your authorized representative), the attending Physician, and your Employer. If you or your authorized representative has any questions about what to do, please contact us directly.

Claims Procedures

We will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if we determine that such an extension is necessary due to matters beyond the control of the plan and we notify you of the circumstances requiring the extension of time and the date by which we expect to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the decision will be made with the information we have in the file.

Adverse Benefit Determination

An adverse benefit determination means a denial, a reduction, a termination or rescission of coverage, or a failure to provide or make payment for a benefit. If your claim is denied, this is considered an adverse benefit determination. If there is an adverse benefit determination, we will send a notice. Notice may be provided in Written or electronic form. Electronic notices will be provided only when you give your consent to receive the notice. The adverse benefit determination will include the following:

- the specific reason(s) for the determination. This may include an explanation of:
    - **What you sent:** The views of health care professionals treating you and the vocational professional who evaluated you. These will be reports that you provided;
    - **Experts from the Plan:** The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - **Social Security:** A disability determination made by the Social Security Administration that you provided;
- reference to specific plan provision(s) on which the determination is based;
- when necessary, a description of additional material or information needed to complete the claim and why such information is necessary;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the claim for benefits;
- identification of any internal rule, guideline, protocol, or standard relied on for the claim determination;
- the plan procedures and time limits for appealing; and
- your right to obtain information about the appeal procedures and the right to bring a lawsuit under section 502(a) of ERISA following an adverse determination from us on appeal, including the limitation that any such lawsuit is brought no later than 3 years from the time Proof of claim was required.

Right to appeal if there is an Adverse Benefit Determination

You or someone you name to act for you (authorized representative) may file an appeal. If someone files an appeal on your behalf, you must let us know that you have appointed this person as your authorized representative. Your appeal must be In Writing and sent to us. When you send your appeal, you may include Written comments, documents, records, or other information related to your claim. You have the right to one appeal.

Time Frame. You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. The appeal will be reviewed, and a determination notice will be sent within 45 days of receiving the appeal. Sometimes, it will take longer to review the appeal because additional information is needed to make a decision. If this happens, within 45-days, we will let you know that an extension is necessary and the reason for the extension. The review period may be extended twice, 90 days in total. If an extension is given to give you more time to submit information necessary to decide the appeal, the letter we send will tell you what is needed. You will be given 45-days to provide the information. The extension of time to review the information will begin after the requested information is received. If you fail to send the requested information, the appeal will be decided based on the information we have at the end of the 45 days.

Information used to make an appeal decision. You will have the opportunity to submit Written comments, documents, or other information in support of your appeal. If we receive additional evidence or rationales that were not included when the benefit was first denied, we will notify you and give you a reasonable opportunity to respond to the information before the plan's decision is due.

Appeal Review. The appeal will be reviewed by someone who did not make the initial decision. This reviewer will look at all the information submitted and may consult with a qualified medical professional. The appeal reviewer will not give consideration to the initial decision. The appeal reviewer will review the evidence and the rationale that was included when the benefit was first denied. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or someone who works for them. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon. In selecting a health care professional to review the appeal, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) are not made based upon the likelihood that the individual will support the denial of benefits. If we receive additional evidence or rationales that were not included when the benefit was first denied, we will notify you and give you a reasonable opportunity to respond to the information before the plan's decision is due.

Appeal Decision. We will send a notice of the appeal decision. Notice may be provided in Written or electronic form. Electronic notices will be provided only when you give your consent to receive the notice. The appeal determination will include the following:

- the specific reason(s) for the determination. This may include an explanation of:
    - **What you sent:** The views of health care professionals treating you and the vocational professional who evaluated you. These will be reports that you provided;
    - **What we received or obtained:** A description of any new information received or obtained during the claim review or appeal review;
    - **Experts from the Plan:** The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - **Social Security:** A disability determination made by the Social Security Administration that you provided;
- reference to specific plan provision(s) on which the determination is based;
- when necessary, a description of additional material or information needed to complete the claim and why such information is necessary;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the claim for benefits; and
- your right to obtain information about the appeal procedures and the right to bring a lawsuit under section 502(a) of ERISA following an adverse determination from us on appeal, including the limitation that any such lawsuit is brought no later than 3 years from the time Proof of claim was required.

Requirement to File an Internal Appeal Before Filing a Lawsuit

If your claim is denied, in whole or in part, after you have completed the appeal procedure, you may file a civil action in federal court under ERISA.